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2003 STATE OF ILLINOIS DEPARTMENT OF PUBLIC AID FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES (FISCAL YEAR 2003)

IMPORTANT NOTICE

THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I.	IDPH Facility ID Number: 00342	256		II. CERTIFI	ICATION BY AUTHORIZED FACILITY OFFICER
	Facility Name: MASON CITY AREA NUR Address: 520 N. PRICE AVENUE Number County: Mason Telephone Number: (217) 482-5022	Mason City City Fax # ()	61938 Zip Code	State of II and certif are true, a applicable	examined the contents of the accompanying report to the Illinois, for the period from 01/01/2003 to 12/31/2003 The first to the best of my knowledge and belief that the said contents accurate and complete statements in accordance with e instructions. Declaration of preparer (other than provider) on all information of which preparer has any knowledge.
	IDPA ID Number: 371168043001				onal misrepresentation or falsification of any information st report may be punishable by fine and/or imprisonment.
	Date of Initial License for Current Owners: Type of Ownership:	02/16/89		Officer or	Signed) (Date) Type or Print Name) Joyce Conrady
	xx VOLUNTARY,NON-PROFIT xx Charitable Corp.	PROPRIETARY Individual	GOVERNMENTAL State		Title) Administrator
	Trust	Partnership	County	(5	Signed)
	IRS Exemption Code	Corporation "Sub-S" Corp. Limited Liability Co. Trust Other	Other	Preparer al	Print Name Craig L. Ater Heritage Enterprises Address)
	In the event there are further questions about th Name: CRAIG L. ATER	nis report, please contact: Telephone Number: ()		- [Telephone) (309)823-7135 Fax # () MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630

STATE OF ILLINOIS Page 2

Faci	lity Name & ID Numb	oer MASON CIT	Y AREA NURSING	Э НОМЕ			# 0034256 Report Period Beginning: 01/01/2003 Ending: 12/31/2003
	III. STATISTICA	L DATA					D. How many bed-hold days during this year were paid by Public Aid?
	A. Licensure/o	certification level(s) of	f care; enter numbei	of beds/bed days,			(Do not include bed-hold days in Section B.)
	(must agree	with license). Date of	change in licensed b	eds			
			-	_		_	E. List all services provided by your facility for non-patients.
	1	2		3	4		(E.g., day care, "meals on wheels", outpatient therapy)
							None
	Beds at				Licensed		
	Beginning of	Licensu	re	Beds at End of	Bed Days During		F. Does the facility maintain a daily midnight census?
	Report Period	Level of		Report Period	Report Period		112500 the menty mannan a any mangne consust
	Report I criou	Ecver or v	Curc	report reriou	Report Feriou		G. Do pages 3 & 4 include expenses for services or
1	33	Skilled (SNI	F)	33	12,045	1	investments not directly related to patient care?
2	33		atric (SNF/PED)	33	12,043	2	YES NO xx
3	33	Intermediat		33	12,045	3	
4		Intermediat	· /		12,010	4	H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
5	31	Sheltered C		31	11,315	5	YES NO xx
6		ICF/DD 16	()	_	,	6	
							I. On what date did you start providing long term care at this location?
7	97	TOTALS		97	35,405	7	Date started 02/16/89
							<u> </u>
							J. Was the facility purchased or leased after January 1, 1978?
	B. Census-For	r the entire report per	riod.				YES Date NO xx
	1	2	3	4	5		
	Level of Care	Patient Days	by Level of Care an	d Primary Source of	Payment		K. Was the facility certified for Medicare during the reporting year?
		Public Aid				1	YES xx NO If YES, enter number
		Recipient	Private Pay	Other	Total		of beds certified and days of care provided 2,038
8	SNF	10,444	6,618	2,038	19,100	8	
9	SNF/PED			0		9	Medicare Intermediary
10	ICF					10	
11	ICF/DD					11	IV. ACCOUNTING BASIS
12	SC	0	5,209	0	5,209	12	MODIFIED
13	DD 16 OR LESS					13	ACCRUAL XX CASH* CASH*
14	TOTALS	10,444	11,827	2,038	24,309	14	Is your fiscal year identical to your tax year? YES xx NO
	C Percent Oc	cupancy. (Column 5,	line 14 divided by to	tal licensed			Tax Year: Fiscal Year:
		n line 7, column 4.)	68.66%	un necuscu			* All facilities other than governmental must report on the accrual basis.
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Page 3 12/31/2003 Facility Name & ID Number MASON CITY AREA NURSING HOME # 0034256 **Report Period Beginning:** 01/01/2003 **Ending:**

	V. COST CENTER EXPENSES (through	hout the report,	please round to	the nearest dol	llar)							•
			osts Per Genera			Reclass-	Reclassified	Adjust-	Adjusted	FOR OHF	USE ONLY	
	Operating Expenses	Salary/Wage	Supplies	Other	Total	ification	Total	ments	Total			
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	185,760	13,605		199,365		199,365		199,365			1
2	Food Purchase		116,988		116,988		116,988		116,988			2
3	Housekeeping	52,635	13,312		65,947		65,947		65,947			3
4	Laundry	41,557	6,596		48,153		48,153		48,153			4
5	Heat and Other Utilities			58,368	58,368		58,368		58,368			5
6	Maintenance	57,655	20,811	30,313	108,779		108,779		108,779			6
7	Other (specify):*											7
8	TOTAL General Services	337,607	171,312	88,681	597,600		597,600		597,600			8
	B. Health Care and Programs											
9	Medical Director			9,000	9,000		9,000		9,000			9
10	Nursing and Medical Records	1,022,680	75,805	1,899	1,100,384		1,100,384		1,100,384			10
	Therapy		51,755	153,908	205,663	(77,233)	128,430		128,430			10a
11	Activities	52,728	1,559	1,330	55,617		55,617		55,617			11
12	Social Services	17,401	42	2,123	19,566		19,566		19,566			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,092,809	129,161	168,260	1,390,230	(77,233)	1,312,997		1,312,997			16
	C. General Administration											
17	Administrative	58,234			58,234		58,234		58,234			17
18	Directors Fees											18
19	Professional Services			110,041	110,041		110,041	(8,574)	101,467			19
20	Dues, Fees, Subscriptions & Promotions			52,047	52,047	(45,243)	6,804	(6,373)	431			20
21	Clerical & General Office Expenses	146,542	11,105	15,502	173,149		173,149		173,149			21
22	Employee Benefits & Payroll Taxes			315,450	315,450		315,450		315,450			22
23	Inservice Training & Education			1,999	1,999		1,999		1,999			23
24	Travel and Seminar			5,444	5,444		5,444	(3,445)	1,999			24
25	Other Admin. Staff Transportation							·				25
26	Insurance-Prop.Liab.Malpractice			72,363	72,363		72,363		72,363			26
27	Other (specify):*											27
28	TOTAL General Administration	204,776	11,105	572,846	788,727	(45,243)	743,484	(18,392)	725,092			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,635,192	311,578	829,787	2,776,557	(122,476)	2,654,081	(18,392)	2,635,689			29

**Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

MASON CITY AREA NURSING HOME

#0034256

Report Period Beginning:

01/01/2003 Ending:

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V. COST CENTER EXPENSES (continued)

			Cost Per Gener	al Ledger		Reclass-	Reclassified	Adjust-	Adjusted	FOR OHF	USE ONLY	
	Capital Expense	Salary/Wage	Supplies	Other	Total	ification	Total	ments	Total			
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			123,388	123,388		123,388	(6,360)	117,028			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			5,838	5,838		5,838	(5,838)				32
33	Real Estate Taxes			3,522	3,522		3,522	(3,522)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			2,840	2,840		2,840	(830)	2,010			35
36	Other (specify):*											36
37	TOTAL Ownership			135,588	135,588		135,588	(16,550)	119,038			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					77,233	77,233		77,233			39
40	Barber and Beauty Shops		565	11,080	11,645		11,645		11,645			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					45,243	45,243		45,243			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		565	11,080	11,645	122,476	134,121		134,121	•		44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	1,635,192	312,143	976,455	2,923,790		2,923,790	(34,942)	2,888,848			45

^{*}Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Report Period Beginning:

01/01/2003

Ending:

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VI. ADJUSTMENT DETAIL

0034256 A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

2 Other Care for Outpatients 3 3 3 3 4 Non-Patient Meals 4 4 Non-Patient Meals 5 5 6 Rented Facility Space 34 6 6 7 Sale of Supplies to Non-Patients 8 Laundry for Non-Patients 8 Laundry for Non-Patients 8 4 6 7 8 Laundry for Non-Patients 8 Laundry for Non-Patients 8 10 10 Interest and Other Investment Income 32 10 11 10 11 10 10 11 10 10 11 10 10 11 10 10 11 10 10 11 10 10 11 10		NON-ALLOWABLE EXPENSES	Amount	2 Refer- ence	OHF USE ONLY	
3 Governmental Sponsored Special Programs 3 4 Non-Patient Meals 4 4 5 Telephone, TV & Radio in Resident Rooms (830) 35 5 5 6 Rented Facility Space 34 6 6 7 Sale of Supplies to Non-Patients 7 8 Laundry for Non-Patients 8 Laundry for Non-Patients 8 4 8 Non-Straightline Depreciation (6,360) 30 9 9 10 Interest and Other Investment Income 32 10 11 Discounts, Allowances, Rebates & Refunds 11 Non-Working Officer's or Owner's Salary 12 13 Sales Tax 2 13 14 Non-Care Related Interest (5,838) 32 14 15 Non-Care Related Owner's Transactions (3,522) 33 15 16 Personal Expenses (Including Transportation) 24 16 17 Non-Care Related Fees (40) 20 17 18 Fines and Penalties 18 19 Entertainment (3,445) 24 19 20 Contributions 27 20 20 Contributions 27 20 20 21 22 3 Malpractice Insurance 21 Owner or Key-Man Insurance 22 Special Legal Fees & Legal Retainers (8,574) 19 22 23 Malpractice Insurance for Individuals 23 24 Bad Debt 27 24 25 Fund Raising, Advertising and Promotional (6,333) 20 25 Income Taxes and Illinois Personal 26 Property Replacement Tax 26 Property Replacement Tax 26 27 28 Yellow Page Advertising 28 29 Other-Attach Schedule 29 20 Other-Attach Schedule 20 Other-A		Day Care	\$		\$	
4 Non-Patient Meals 4 5 Telephone, TV & Radio in Resident Rooms (830) 35 5 6 Rented Facility Space 34 6 7 Sale of Supplies to Non-Patients 7 8 Laundry for Non-Patients 8 9 Non-Straightline Depreciation (6,360) 30 9 10 Interest and Other Investment Income 32 10 11 Discounts, Allowances, Rebates & Refunds 11 11 12 Non-Working Officer's or Owner's Salary 12 13 13 Sales Tax 2 13 14 Non-Care Related Interest (5,838) 32 14 15 Non-Care Related Owner's Transactions (3,522) 33 15 16 Personal Expenses (Including Transportation) 24 16 17 Non-Care Related Fees (40) 20 17 18 Fines and Penalties 18 18 19 Entertainment (3,445) 24 19 20 Contributions 27 <td>2</td> <td></td> <td></td> <td></td> <td></td> <td></td>	2					
5 Telephone, TV & Radio in Resident Rooms (830) 35 5 6 Rented Facility Space 34 6 7 Sale of Supplies to Non-Patients 7 8 Laundry for Non-Patients 8 9 Non-Straightline Depreciation (6,360) 30 9 10 Interest and Other Investment Income 32 10 11 Discounts, Allowances, Rebates & Refunds 11 11 12 Non-Working Officer's or Owner's Salary 12 13 13 Sales Tax 2 13 14 Non-Care Related Interest (5,838) 32 14 15 Non-Care Related Owner's Transactions (3,522) 33 15 16 Personal Expenses (Including Transportation) 24 16 17 Non-Care Related Fees (40) 20 17 18 Fines and Penalties 18 18 19 Entertainment (3,445) 24 19 20 Contributions	3					3
6 Rented Facility Space 34 6 7 Sale of Supplies to Non-Patients 7 8 Laundry for Non-Patients 8 9 Non-Straightline Depreciation (6,360) 30 9 10 Interest and Other Investment Income 32 10 11 Discounts, Allowances, Rebates & Refunds 11 12 Non-Working Officer's or Owner's Salary 12 13 Sales Tax 2 13 14 Non-Care Related Interest (5,838) 32 14 15 Non-Care Related Owner's Transactions (3,522) 33 15 16 Personal Expenses (Including Transportation) 24 16 17 Non-Care Related Fees (40) 20 17 18 Fines and Penalties 18 18 19 Entertainment (3,445) 24 19 20 Contributions 27 20 21 Owner or Key-Man Insurance (8,574) 19 22 <t< th=""><td>4</td><td></td><td></td><td></td><td></td><td></td></t<>	4					
7 Sale of Supplies to Non-Patients 7 8 Laundry for Non-Patients 8 9 Non-Straightline Depreciation (6,360) 30 9 10 Interest and Other Investment Income 32 10 11 Discounts, Allowances, Rebates & Refunds 111 12 Non-Working Officer's or Owner's Salary 12 13 Sales Tax 2 13 14 Non-Care Related Interest (5,838) 32 14 15 Non-Care Related Gwner's Transactions (3,522) 33 15 16 Personal Expenses (Including Transportation) 24 16 17 Non-Care Related Fees (40) 20 17 18 Fines and Penalties 18 19 Entertainment (3,445) 24 19 20 Contributions 27 20 21 Owner or Key-Man Insurance 27 20 21 Owner or Key-Man Insurance (8,574) 19 22 23 Malpractice Ins	5		(830)	35		5
8 Laundry for Non-Patients 8 9 Non-Straightline Depreciation (6,360) 30 9 10 Interest and Other Investment Income 32 10 11 Discounts, Allowances, Rebates & Refunds 11 12 Non-Working Officer's or Owner's Salary 12 13 Sales Tax 2 13 14 Non-Care Related Interest (5,838) 32 14 15 Non-Care Related Owner's Transactions (3,522) 33 15 16 Personal Expenses (Including Transportation) 24 16 17 Non-Care Related Fees (40) 20 17 18 Fines and Penalties 18 19 Entertainment (3,445) 24 19 20 Contributions 27 20 27 20 21 Owner or Key-Man Insurance 21 27 20 22 Special Legal Fees & Legal Retainers (8,574) 19 22 23 Malpractice Insurance for Individu	6	Rented Facility Space		34		6
9 Non-Straightline Depreciation (6,360) 30 9 10 Interest and Other Investment Income 32 10 11 Discounts, Allowances, Rebates & Refunds 11 12 Non-Working Officer's or Owner's Salary 12 13 Sales Tax 2 13 14 Non-Care Related Interest (5,838) 32 14 15 Non-Care Related Owner's Transactions (3,522) 33 15 16 Personal Expenses (Including Transportation) 24 16 17 Non-Care Related Fees (40) 20 17 18 Fines and Penalties 18 18 18 19 Entertainment (3,445) 24 19 20 Contributions 27 20 21 Owner or Key-Man Insurance 27 20 21 Owner or Key-Man Insurance (8,574) 19 22 23 Malpractice Insurance for Individuals 23 24 24 24 Bad Debt 27 24 25 Fund Raising, Advertising and Promotional (6,333) 20 25 Income Taxes and Illinois Perso	7	Sale of Supplies to Non-Patients				7
10 Interest and Other Investment Income 32 10 11 Discounts, Allowances, Rebates & Refunds 11 12 Non-Working Officer's or Owner's Salary 12 13 Sales Tax 2 13 14 Non-Care Related Interest (5,838) 32 14 15 Non-Care Related Owner's Transactions (3,522) 33 15 16 Personal Expenses (Including Transportation) 24 16 17 Non-Care Related Fees (40) 20 17 18 Fines and Penalties 18 19 Entertainment (3,445) 24 19 20 Contributions 27 20 21 Owner or Key-Man Insurance 21 22 Special Legal Fees & Legal Retainers (8,574) 19 22 23 Malpractice Insurance for Individuals 23 24 Bad Debt 27 24 25 Fund Raising, Advertising and Promotional (6,333) 20 25 Income Taxes and Illinois Personal 26 26 Property Replacement Tax 26 27 Nurse Aide Training for Non-Employees 27 28 Yellow Page Advertising 28 29 Other-Attach Schedule 29	8	Laundry for Non-Patients				8
11 Discounts, Allowances, Rebates & Refunds 11 12 Non-Working Officer's or Owner's Salary 12 13 Sales Tax 2 13 14 Non-Care Related Interest (5,838) 32 14 15 Non-Care Related Owner's Transactions (3,522) 33 15 16 Personal Expenses (Including Transportation) 24 16 17 Non-Care Related Fees (40) 20 17 18 Fines and Penalties 18 19 19 Entertainment (3,445) 24 19 20 Contributions 27 20 21 Owner or Key-Man Insurance 21 22 22 Special Legal Fees & Legal Retainers (8,574) 19 22 23 Malpractice Insurance for Individuals 23 24 24 Bad Debt 27 24 25 Fund Raising, Advertising and Promotional (6,333) 20 25 Income Taxes and Illinois Personal 26 Property Replacement Tax 26 27 Nurse Aide Training for Non-Employees 27 28 28 Yellow Page Advertising 28 29 Other-Attach Schedule 29 <td>9</td> <td>Non-Straightline Depreciation</td> <td>(6,360)</td> <td>30</td> <td></td> <td>9</td>	9	Non-Straightline Depreciation	(6,360)	30		9
12 Non-Working Officer's or Owner's Salary 12 13 Sales Tax 2 13 14 Non-Care Related Interest (5,838) 32 14 15 Non-Care Related Owner's Transactions (3,522) 33 15 16 Personal Expenses (Including Transportation) 24 16 17 Non-Care Related Fees (40) 20 17 18 Fines and Penalties 18 19 Entertainment (3,445) 24 19 20 Contributions 27 20 21 Owner or Key-Man Insurance 21 22 Special Legal Fees & Legal Retainers (8,574) 19 22 23 Malpractice Insurance for Individuals 23 24 Bad Debt 27 24 25 Fund Raising, Advertising and Promotional (6,333) 20 25 Income Taxes and Illinois Personal 26 Property Replacement Tax 26 Property Replacement Tax 27 28 Yellow Page Advertising 28 29 Other-Attach Schedule 29 29 29 Other-Attach Schedule 29 29 29 29 29 29 29 2	10	Interest and Other Investment Income		32		10
13 Sales Tax 2 13 14 Non-Care Related Interest (5,838) 32 14 15 Non-Care Related Owner's Transactions (3,522) 33 15 16 Personal Expenses (Including Transportation) 24 16 17 Non-Care Related Fees (40) 20 17 18 Fines and Penalties 18 19 Entertainment (3,445) 24 19 20 Contributions 27 20 21 Owner or Key-Man Insurance 21 22 Special Legal Fees & Legal Retainers (8,574) 19 22 23 Malpractice Insurance for Individuals 23 24 Bad Debt 27 24 25 Fund Raising, Advertising and Promotional (6,333) 20 25 Income Taxes and Illinois Personal 26 27 Property Replacement Tax 26 28 Yellow Page Advertising 28 29 Other-Attach Schedule 29	11					11
14 Non-Care Related Interest (5,838) 32 14 15 Non-Care Related Owner's Transactions (3,522) 33 15 16 Personal Expenses (Including Transportation) 24 16 17 Non-Care Related Fees (40) 20 17 18 Fines and Penalties 18 19 Entertainment (3,445) 24 19 20 Contributions 27 20 21 Owner or Key-Man Insurance 21 22 22 Special Legal Fees & Legal Retainers (8,574) 19 22 23 Malpractice Insurance for Individuals 23 24 24 25 24 Bad Debt 27 24 25 Fund Raising, Advertising and Promotional (6,333) 20 25 Income Taxes and Illinois Personal 26 26 Property Replacement Tax 26 27 Nurse Aide Training for Non-Employees 27 28 Yellow Page Advertising 28 29 Other-Attach Schedule 29	12	Non-Working Officer's or Owner's Salary				12
15 Non-Care Related Owner's Transactions (3,522) 33 15 16 Personal Expenses (Including Transportation) 24 16 17 Non-Care Related Fees (40) 20 17 18 Fines and Penalties 18 19 Entertainment (3,445) 24 19 20 Contributions 27 20 21 Owner or Key-Man Insurance 21 22 Special Legal Fees & Legal Retainers (8,574) 19 22 23 Malpractice Insurance for Individuals 23 24 Bad Debt 27 24 25 Fund Raising, Advertising and Promotional (6,333) 20 25 Income Taxes and Illinois Personal 26 Property Replacement Tax 26 27 Nurse Aide Training for Non-Employees 27 28 Yellow Page Advertising 28 29 Other-Attach Schedule 29	13	Sales Tax		2		13
16 Personal Expenses (Including Transportation) 24 16 17 Non-Care Related Fees (40) 20 17 18 Fines and Penalties 18 19 Entertainment (3,445) 24 19 20 Contributions 27 20 21 Owner or Key-Man Insurance 21 22 22 Special Legal Fees & Legal Retainers (8,574) 19 22 23 Malpractice Insurance for Individuals 23 24 Bad Debt 27 24 25 Fund Raising, Advertising and Promotional (6,333) 20 25 Income Taxes and Illinois Personal 26 Property Replacement Tax 26 27 Nurse Aide Training for Non-Employees 27 28 28 Yellow Page Advertising 28 29 Other-Attach Schedule 29	14	Non-Care Related Interest	(5,838)	32		14
17 Non-Care Related Fees (40) 20 17 18 Fines and Penalties 18 19 Entertainment (3,445) 24 19 20 Contributions 27 20 21 Owner or Key-Man Insurance 21 22 Special Legal Fees & Legal Retainers (8,574) 19 22 23 Malpractice Insurance for Individuals 23 24 Bad Debt 27 24 25 Fund Raising, Advertising and Promotional (6,333) 20 25 Income Taxes and Illinois Personal 26 26 Property Replacement Tax 26 27 Nurse Aide Training for Non-Employees 27 28 Yellow Page Advertising 28 29 Other-Attach Schedule 29	15	Non-Care Related Owner's Transactions	(3,522)	33		15
18 Fines and Penalties 18 19 Entertainment (3,445) 24 19 20 Contributions 27 20 21 Owner or Key-Man Insurance 21 22 Special Legal Fees & Legal Retainers (8,574) 19 22 23 Malpractice Insurance for Individuals 23 24 Bad Debt 27 24 25 Fund Raising, Advertising and Promotional (6,333) 20 25 Income Taxes and Illinois Personal 26 26 Property Replacement Tax 26 27 Nurse Aide Training for Non-Employees 27 28 Yellow Page Advertising 28 29 Other-Attach Schedule 29				24		16
19 Entertainment (3,445) 24 19 20 Contributions 27 20 21 Owner or Key-Man Insurance 21 22 Special Legal Fees & Legal Retainers (8,574) 19 22 23 Malpractice Insurance for Individuals 23 24 Bad Debt 27 24 25 Fund Raising, Advertising and Promotional (6,333) 20 25 Income Taxes and Illinois Personal 26 Property Replacement Tax 26 27 Nurse Aide Training for Non-Employees 27 28 Yellow Page Advertising 28 29 Other-Attach Schedule 29	17		(40)	20		17
20 Contributions 27 20 21 Owner or Key-Man Insurance 21 22 Special Legal Fees & Legal Retainers (8,574) 19 22 23 Malpractice Insurance for Individuals 23 23 24 Bad Debt 27 24 25 Fund Raising, Advertising and Promotional (6,333) 20 25 Income Taxes and Illinois Personal 26 Property Replacement Tax 26 27 Nurse Aide Training for Non-Employees 27 28 28 Yellow Page Advertising 28 29 Other-Attach Schedule 29	18	Fines and Penalties				18
21 Owner or Key-Man Insurance 21 22 Special Legal Fees & Legal Retainers (8,574) 19 22 23 Malpractice Insurance for Individuals 23 24 24 25 End Raising, Advertising and Promotional (6,333) 20 25 Income Taxes and Illinois Personal 26 Property Replacement Tax 26 27 27 Nurse Aide Training for Non-Employees 27 28 Yellow Page Advertising 28 29 Other-Attach Schedule 29	19	Entertainment	(3,445)	24		19
22 Special Legal Fees & Legal Retainers (8,574) 19 22 23 Malpractice Insurance for Individuals 23 24 Bad Debt 27 24 25 Fund Raising, Advertising and Promotional (6,333) 20 25 Income Taxes and Illinois Personal 26 Property Replacement Tax 26 27 Nurse Aide Training for Non-Employees 27 28 28 Yellow Page Advertising 28 29 Other-Attach Schedule 29	20	Contributions		27		20
23 Malpractice Insurance for Individuals 23 24 Bad Debt 27 24 25 Fund Raising, Advertising and Promotional (6,333) 20 25 Income Taxes and Illinois Personal 26 Property Replacement Tax 26 27 27 Nurse Aide Training for Non-Employees 27 28 Yellow Page Advertising 28 29 Other-Attach Schedule 29						21
24 Bad Debt 27 24 25 Fund Raising, Advertising and Promotional (6,333) 20 25 Income Taxes and Illinois Personal 26 Property Replacement Tax 26 27 Nurse Aide Training for Non-Employees 27 28 Yellow Page Advertising 28 29 Other-Attach Schedule 29	22	Special Legal Fees & Legal Retainers	(8,574)	19		22
25 Fund Raising, Advertising and Promotional (6,333) 20 25 Income Taxes and Illinois Personal 26 Property Replacement Tax 26 27 Nurse Aide Training for Non-Employees 27 28 Yellow Page Advertising 28 29 Other-Attach Schedule 29	23					23
Income Taxes and Illinois Personal 26 Property Replacement Tax 26 27 Nurse Aide Training for Non-Employees 27 28 Yellow Page Advertising 28 29 Other-Attach Schedule 29 29	24			27		24
Income Taxes and Illinois Personal 26 Property Replacement Tax 26 27 Nurse Aide Training for Non-Employees 27 28 Yellow Page Advertising 28 29 Other-Attach Schedule 29 29	25	Fund Raising, Advertising and Promotional	(6,333)	20		25
27 Nurse Aide Training for Non-Employees 27 28 Yellow Page Advertising 28 29 Other-Attach Schedule 29		Income Taxes and Illinois Personal				
28 Yellow Page Advertising 28 29 Other-Attach Schedule 29						26
29 Other-Attach Schedule 29						27
30 SUBTOTAL (A): (Sum of lines 1-29) \$ (34,942) \$ 30						
	30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (34,942)		\$	30

	OHF USE ONL	Y				
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below. (See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (34,942)		37

^{*}These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions)

(Se	e instructions.)	1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

STATE OF ILLINOIS

Page 5A

MASON CITY AREA NURSING HOME

| ID# | 0034256 | Report Period Beginning: 01/01/2003 | Ending: 12/31/2003

Sch. V Line

				Sch. V Line	
	NON-ALLOWABLE EXPENSES		Amount	Reference	
1		\$			1
2					2
3					3
4			(0.00)		4
5			(830)	35	5
6			0	34	6
7					7
8					8
9			(6,360)	30	9
10				32	10
11					11
12					12
13			0	2	13
_				32	14
14			(5,838)		
15			(3,522)	33	15
16				24	16
17			(40)	20	17
18					18
19				24	19
20			0	27	20
21					21
22			(8,574)	19	22
23			(-,- ,		23
24			0	27	24
25			(6,333)	20	25
26			(0,555)	20	26
27					27
					_
28					28
29					29
30					30
31					31
32					32
33					33
34					34
35					35
36					36
37					37
38					38
39					39
_					
40					40
41					41
42					42
43					43
44					44
45					45
46					46
47					47
48					48
49	Total		(31,497)		49
<u>ٺ</u>			(0.,.01)		

STATE OF ILLINOIS

Summary A Facility Name & ID Number MASON CITY AREA NURSING HOME SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I 01/01/2003 Ending: # 0034256 Report Period Beginning: 12/31/2003

	SUMMARY OF PAGES 5, 5A, 6, 6A	1, ов, ос, ор, с	ъ., ог, ос, оп	AND OI			I						CUMMADA
	0 " "	D. CEG	D. CE	D. CE	D. CE	D. CE	D. CE	D. CE	D. CE	D. CE	D. CE	D. CE	SUMMARY
-	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	TOTALS
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0 1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0 2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0 3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0 4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0 5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0 6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 7
8	TOTAL General Services	0	0	0	0	0	0	0	0	0	0	0	0 8
	B. Health Care and Programs												
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0 9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0 10
10a	1.5	0	0	0	0	0	0	0	0	0	0	0	0 10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0 11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0 12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0 13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0 14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0 16
	C. General Administration												
17		0	0	0	0	0	0	0	0	0	0	0	0 17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0 18
19	Professional Services	(8,574)	0	0	0	0	0	0	0	0	0	0	(8,574) 19
20	Fees, Subscriptions & Promotions	(6,373)	0	0	0	0	0	0	0	0	0	0	(6,373) 20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0 21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0 22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0 23
24	Travel and Seminar	(3,445)	0	0	0	0	0	0	0	0	0	0	(3,445) 24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0 25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0 26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 27
28	TOTAL General Administration	(18,392)	0	0	0	0	0	0	0	0	0	0	(18,392) 28
	TOTAL Operating Expense												
29	(sum of lines 8,16 & 28)	(18,392)	0	0	0	0	0	0	0	0	0	0	(18,392) 29

STATE OF ILLINOIS Summary B Facility Name & ID Number MASON CITY AREA NURSING HOME # 0034256 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

													SUMMARY	
	Capital Expense	PAGES	PAGE	PAGE	PAGE	TOTALS								
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6 G	6H	6 I	(to Sch V, col	.7)
30	Depreciation	(6,360)	0	0	0	0	0	0	0	0	0	0	(6,360)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(5,838)	0	0	0	0	0	0	0	0	0	0	(5,838)	32
33	Real Estate Taxes	(3,522)	0	0	0	0	0	0	0	0	0	0	(3,522)	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	(830)	0	0	0	0	0	0	0	0	0	0	(830)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(16,550)	0	0	0	0	0	0	0	0	0	0	(16,550)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST		•				·							
45	(sum of lines 29, 37 & 44)	(34,942)	0	0	0	0	0	0	0	0	0	0	(34,942)	45

0034256

A. Enter below the names of AL	L owners and rei	ated organizations (parties) as defined in tr	ie instructions. Attach a	n additional schedu	ne ii necessary.		
1		2	3				
OWNERS		RELATED NURSING HOM	OTHER RELATED BUSINESS ENTITIES				
Name	Ownership %	Name	City	Name	City	Type of Business	
B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent,							

management fees, purchase of supplies, and so forth.

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

_	-		for determining costs as specifical						
	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
						Percent	Operating Cost	Adjustments for	
Sch	edule V	Line	Item	Amount	Name of Related Organization	of	of Related	Related Organization	
						Ownership		Costs (7 minus 4)	
	*7			0		Ownership	or gamzation	Costs (7 mmus 4)	
1	V			3			5	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	14

^{*} Total must agree with the amount recorded on line 34 of Schedule VI.

0034256

01/01/2003

Ending:

12/31/2003

Report Period Beginning:

VII. RELATED PARTIES (continued)

Facility Name & ID Number

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

MASON CITY AREA NURSING HOME

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	(6	7		8	
						Average Hours Per Work					
					Compensation	Week Devo	oted to this	Compensati	on Included	Schedule V.	
					Received	Facility and	l % of Total	in Costs	for this	Line &	
				Ownership	From Other	Work	Week	Reportin	ng Period**	Column	
	Name	Title	Function	Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
1	None								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

^{*} If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

^{**} This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME. ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

C	r a r	rr.	OF	TT	T	NIO	TC	

Page 8 Facility Name & ID Number MASON CITY AREA NURSING HOME 01/01/2003 Ending: 2/31/2003 # 0034256 Report Period Beginning:

VIII. ALLOCATION OF INDIRECT COSTS

	Name of Related Organization	
A. Are there any costs included in this report which were derived from allocations of central office	Street Address	
or parent organization costs? (See instructions.) YES NO	City / State / Zip Code	
-	Phone Number	()
B. Show the allocation of costs below. If necessary, please attach worksheets.	Fax Number	

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary			
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Facility	Allocation	
	Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6	Units	(col.8/col.4)x col.6	
1			1			\$	\$		\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11 12
12										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		S	25

Report Period Beginning:

01/01/2003 Ending:

Page 9 12/31/2003

IX	INTEREST	EXPENSE	AND REAL	ESTATE	TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2	3	4	5	6	7	8	9	10	
	Name of Lender	Related**	Purpose of Loan	Monthly Payment	Date of		unt of Note	Maturity Date	Interest Rate	Reporting Period Interest	
		YES NO		Required	Note	Original	Balance		(4 Digits)	Expense	
	A. Directly Facility Related										
	Long-Term										
1						\$	\$			\$	1
2											2
3											3
4											4
5											5
	Working Capital										
6											6
7											7
8											8
9	TOTAL Facility Related					\$	\$			\$	9
	B. Non-Facility Related*										
	Interest Income										10
11											11
12											12
13											13
14	TOTAL Non-Facility Related					\$	\$			\$	14
15	TOTALS (line 9+line14)					\$	\$			\$	15

16)	Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V.	\$	Line#	
			-	

^{*} Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

^{**} If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

STATE OF ILLINOIS Page 10
0034256 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

Facility Name & ID Number MASON CITY AREA NURSING HOME

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

B. Real Estate Taxes					
	Important, please see the next workshee	et, "RE_Tax". The real	estate tax statement and		
1. Real Estate Tax accrual used on 2002 report.	bill must accompany the cost report.			\$	1
2. Real Estate Taxes paid during the year: (Indicate	the tax year to which this payment applies. If payment co	overs more than one year, de	tail below.)	s	2
3. Under or (over) accrual (line 2 minus line 1).				s	3
4. Real Estate Tax accrual used for 2003 report. (De	etail and explain your calculation of this accrual on the li	nes below.)		s	4
**	h has NOT been included in professional fees or other geopies of invoices to support the cost and a cost a cost and a cost a cost a cost and a cost			\$	5
6. Subtract a refund of real estate taxes. You must of classified as a real estate tax cost plus one-half of TOTAL REFUND \$ For	any remaining refund.	real estate tax appeal	board's decision.)	\$	6
7. Real Estate Tax expense reported on Schedule V,	line 33. This should be a combination of lines 3 thru 6.			s	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	1998 8		FOR OHF USE ONLY		
	1999 9 2000 10	13	FROM R. E. TAX STATEMENT F	OR 2002 \$	
	2001				13
	2002 12	14	PLUS APPEAL COST FROM LIN	E5 \$	
		15	PLUS APPEAL COST FROM LINE LESS REFUND FROM LINE 6	E 5 \$	13 14 15

NOTES:

- 1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
- If facility is a non-profit which pays real estate taxes, you must attach a denial of an
 application for real estate tax exemption unless the building is rented from a for-profit entity.
 This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FAC	ILITY NAME MASON	CITY AREA NURSING HOME	COL	JNTY Mas	on
FAC	ILITY IDPH LICENSE NUM	BER 0034256			
CON	ITACT PERSON REGARDIN	IG THIS REPORT			
TEL	EPHONE ()	FAX#:	()		
A.	Summary of Real Estate T:				•
	cost that applies to the operation home property which is vaca	ind real estate tax assessed for 2002 on the tion of the nursing home in Column D. R nt, rented to other organizations, or used t include cost for any period other than ca	eal estate tax applic for purposes other t	cable to any p	ortion of the nursing
	(A)	(B)	(C)	(D)
1. 2. 3. 4. 5. 6. 7. 8. 9.			s s s s s s s s s s s s s s s s s s s		Tax Applicable to Nursing Home S S S S S S S S S S S S S S S S S S
		TOTALS	s s		\$
B.		oill apply to more than one nursing home,		property whi	ch is not directly
	used for nursing home service	ees? YES	_NO		
		n & a schedule which shows the calculation cost must be allocated to the nursing hom			
C	Toy Dille				

 $Attach\ a\ copy\ of\ the\ 2002\ tax\ bills\ which\ were\ listed\ in\ Section\ A\ to\ this\ statement.\ Be\ sure\ to\ use\ the\ 2002\ tax\ bill\ which\ which\ were\ listed\ in\ Section\ A\ to\ this\ statement.$

is normally paid during 2003.

Page 10A

STA	TE	OF	пт	INO	TC

0034256 Report Period Beginning:

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12/31/2003

01/01/2003 Ending:

Facility Name & ID Number MASON CITY AREA NURSING HOME X. BUILDING AND GENERAL INFORMATION: **B.** General Construction Type: **Number of Stories** Square Feet: Exterior (c) Rent from Completely Unrelated Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. Organization. (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.) (c) Rent equipment from Completely Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. Unrelated Organization. (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.) List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable). NO Does this cost report reflect any organization or pre-operating costs which are being amortized? YES If so, please complete the following: 1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized: 3. Current Period Amortization: 4. Dates Incurred: Nature of Costs: (Attach a complete schedule detailing the total amount of organization and pre-operating costs.) XI. OWNERSHIP COSTS: A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Land			\$ 36,000	1
2					2
3	TOTALS			\$ 36,000	3

0034256

Report Period Beginning:

Page 12 01/01/2003 Ending: 12/31/2003

Facility Name & ID Number MASON CITY AREA NURSING HOME # 003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

_	D. Dullul	ng Depreciation-Including Fixed Eq	urpinent. (See inst	uctions.) Roun	d all humbers to hear	est uonar.				9	
	1	EOD OHE LISE ONLY	2	3	4	5 D 1	6	64	8	Accumulated	
	D 14	FOR OHF USE ONLY	Year	Year		Current Book	Life	Straight Line			
	Beds*		Acquired	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
4	97				\$ 2,605,181	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Impro	ovement Type**	•							•	
9	1990 Improve	ements		1990	7,990						9
10	1991 Improve	ements		1991	16,512						10
11	1992 Improve	ements		1992	22,678						11
	1993 Improve			1993							12
13	1994 Improve	ements		1994	24,788						13
14	1995 Improve	ements		1995	17,777						14
15											15
	Water Heater			1997	4,800						16
	Asphalt Seale			1997	5,395						17
18	Entrance & V	Valkway		1997	1,700						18
19	Landscaping			1997	6,770						19
20											20
	Kitch Centra			1996	15,800						21
		Administrative Offices		1996	2,500						22
	Landscapping			1996	2,710						23
	Automatic Do	oor Closers		1996	3,732						24
25											25
	Life Safety A			1998	992						26
	Sound Systen			1998	1,442						27
	Security Syste	em		1998	10,742						28
29											29
	Parking Lot			1999	4,190						30
	Petroleum tai	ık		1999	12,500						31
32											32
33											33
	C/O Allocatio										34
	Book Depreci	ation				82,404		82,404		1,068,353	35
36											36

See Page 12A, Line 70 for total

^{*}Total beds on this schedule must agree with page 2.
**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MASON CITY AREA NURSING HOME # 00

XI. OWNERSHIP COSTS (continued)

R Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dolla

0034256 Report Period Beginning:

01/01/2003 Ending: Page 12A 12/31/2003

B. Building Depreciation-Including Fixed Equipme	nt. (See instructions.) Roun	id all numbers to nea	rest dollar.					
1	3	4	5	6	7	8	9	
	Year	_	Current Book	Life	Straight Line		Accumulated	
Improvement Type**	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
37 Firewallsceilling	2000	\$ 10,800	\$		\$	\$	\$	37
38 Facility RemodelMaterials (Carpeting)	2000	22,660						38
39								39
40 Wallpaper	2001	5,552						40
41 Carpet Installation	2001	4,141						41
42 Woodwork Refinishing	2001	418						42
43 Water Heater	2001	6,125						43
44 Facility RemodelLabor	2001	1,520						44
45 Parking Lot	2001	9,375						45
46 Living room Remodel	2001	415						46
47 Facility RemodelMaterials	2001	23,795						47
48 Ceramic Tile Shower	2001	698						48
49 Hot Water Pump	2001	2,586						49
50 Carpeting and Installation	2001	2,208						50
51 Wander Guard	2001	1,270						51
52 Light Fixtures and Door	2001	2,777						52
53 Flooring	2001	1,311						53
54								54
55 Painting	2002	1,500						55
56 Remodel & Update Nurses Station	2002	13,224						56
57 Decorative consulting	2002	3,982						57
58 Living room Remodel	2002	493						58
59								59
60 Remodel & Update Nurses Station	2003	14,461						60
61 Roof	2003	10,085						61
62 Window Treatments	2003	1,484						62
63 Water Heater	2003	6,355						63
64 Heater/Air Conditioning Unit	2003	1,095						64
65 Rim Device	2003	1,290						65
66 Drywall	2003	2,817						66
67								67
68								68
69								69
70 TOTAL (lines 4 thru 69)		\$ 2,920,636	\$ 82,404		\$ 82,404	\$	\$ 1,068,353	70

^{**}Improvement type must be detailed in order for the cost report to be considered complete.

0034256

Report Period Beginning:

01/01/2003 Ending:

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Facility Name & ID Number MASON CITY AREA NURSING HOME # 003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

B. Building Depreciation-Including Fixed Equipment. (See instru	3	4	5	6	1 7	8	9	1
	Year	•	Current Book	Life	Straight Line		Accumulated	
Improvement Type**	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
1 Totals from Page 12A, Carried Forward		s 2,920,636	\$ 82,404		s 82,404	S	\$ 1,068,353	1
2		-,,	,		,	*	3,000,000	2
3								3
4								4
5								5
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20 21								20 21
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31								31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 2,920,636	\$ 82,404		\$ 82,404	\$	\$ 1,068,353	34

^{**}Improvement type must be detailed in order for the cost report to be considered complete.

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Page 13 MASON CITY AREA NURSING HOME 0034256 01/01/2003 Ending: 12/31/2003 Facility Name & ID Number **Report Period Beginning:**

XI. OWNERSHIP COSTS (continued)

C. Equipment	Depreciation-l	Excluding Tra	nsportation. ((See instructions.)
--------------	----------------	---------------	----------------	--------------------	---

	Category of	1		Current Book	Straight Line	4	Component	Accumulated	
	Equipment	Cost		Depreciation 2	Depreciation 3	Adjustments	Life 5	Depreciation 6	
71	Purchased in Prior Years	\$ 477,57	8	\$ 34,624	\$ 34,624	\$		\$ 411,155	71
72	Current Year Purchases	18,40	8						72
73	Fully Depreciated Assets								73
74									74
75	TOTALS	\$ 495,98	6	\$ 34,624	\$ 34,624	\$		\$ 411,155	75

D. Vehicle Depreciation (See instructions.)*

	1	Model, Make	Year	4	Current Book	Straight Line	7	Life in	Accumulated	
	Use	and Year 2	Acquired 3	Cost	Depreciation 5	Depreciation 6	Adjustments	Years 8	Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

Accumulated Depreciation

	E. Summary of Cart-Actated Assets	1	<u> </u>		
		Reference	Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 3,452,622	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 117,028	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 117,028	83	**
84	Adjustments	(line 70, col $8 + \text{line } 75$, col $4 + \text{line } 80$, col $7) + (Pages 12R thru 12L if applicable)$	\$	84	1

(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	 ent Book eciation 3	Accumulated Depreciation 4	
86	Non-Care Assets	\$ 130,392	\$ 6,360	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 130,392	\$ 6,360	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

1,479,508

Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

This must agree with Schedule V line 30, column 8.

STATE OF ILLINOIS

Page 14

Fac	ility Name & I	D Number	MASON CITY AR	EA NURSING HOM	E	# 0034256	R	eport Period Beginning:	01/01/2003	Ending:	12/31/200
XII	1. Name of 2. Does the	and Fixed Equip Party Holding	pment (See instructions Lease: v real estate taxes in add		nt shown below or	n line 7, column 4?]NO				
		1 Year Constructed	2 Number d of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Yea Renewal Op				
3	Original Building: Additions			\$	201			3 Be	ffective dates of current ginning		nent:
5					10.00			5			
6	TOTAL								tent to be paid in future yental agreement:	ears under t	he current
	This amo by the le 9. Option to B. Equipmer 15. Is Mova	ount was calcularigh of the leas Buy: nt-Excluding Trible equipment	rtization of lease expens ted by dividing the tota e YES ransportation and Fixed rental included in build vable equipment: \$	al amount to be amore NO Terms: Equipment. (See insing rental?	ized	YES pager, computer equip		12. 13. 14. breakdown of movable	/2004 /2005 /2006	Annual Ro \$	
	C. Vehicle R	ental (See instr	uctions.)			(· zomen u seneuu	ic ucuming the		equipment)		
	1 Use		2 Model Year and Make	Monthl Payı	y Lease	4 Rental Expense for this Period	•	*	If there is an option to b	uy the buildi	ng,
17 18 19				\$		\$	17 18 19		please provide complete schedule.	details on at	tached
20							20	**	This amount plus any ar	nortization o	f lease
21	TOTAL			\$		\$	21		expense must agree with	page 4, line	<u>34.</u>

			S	TATE OF ILLI						Page 15
	ame & ID Number MASON CITY AREA				# 0034	1256 Report	Period Beginning:	01/01/2003	Ending:	12/31/200
XIII. EXP	PENSES RELATING TO NURSE AIDE TRAINING	PROGRAMS (See in	structions.)							
А. Т	YPE OF TRAINING PROGRAM (If aides are train	ed in another facility	program, attach a	schedule listing t	he facility name	, address and cos	t per aide trained in	that facility.)		
	1. HAVE YOU TRAINED AIDES DURING THIS REPORT	YES 2.	CLASSROOM	PORTION:		3.	CLINICAL PO	ORTION:	=	
	PERIOD?	NO	IN-HOUSE PR	OGRAM			IN-HOUSE PI	ROGRAM		
	If "yes", please complete the remainder		IN OTHER FA	CILITY			IN OTHER FA	ACILITY		
	of this schedule. If "no", provide an		COMMUNITY	COLLEGE			HOURS PER	AIDE		
	explanation as to why this training was not necessary.		HOURS PER A	AIDE						
В. Е	XPENSES	ALLOCATI	ON OF COSTS	(1)		C	. CONTRACTUAL I	INCOME		
		ALLOCATI	ON OF COSTS	(d)			T., 4b., b., b., b			
		1	2	3		4		ow record the a ed training aide		
		Fa	cility							
		Drop-outs	Completed	Contract	Tot	al	\$			
1	Community College Tuition	\$	\$	\$	\$				-	
2	Books and Supplies					D	. NUMBER OF AID	ES TRAINED		
3	Classroom Wages (a)									
4	Clinical Wages (b)						COMPLE	TED		
5	In-House Trainer Wages (c)						1. From this fa	acility		
6	Transportation						2. From other	facilities (f)		

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.

(e)

TOTALS

7 Contractual Payments

Nurse Aide Competency Tests

SUM OF line 9, col. 1 and 2

(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

(e) The total amount of Drop-out and Completed Costs for

DROP-OUTS

2. From other facilities (f) TOTAL TRAINED

1. From this facility

your own aides must agree with Sch. V, line 13, col. 8. (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Page 16 01/01/2003 Ending: 12/31/2003

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	(1	2	3	4		5	6	7	8	
		Schedule V	Staf	Î	Outsio	Outside Practitioner		Supplies			
	Service	Line & Column	Units of	Cost	(other t	han consu	ıltant)	(Actual or)	Total Units	Total Cost	
		Reference	Service		Units		Cost	Allocated)	(Column 2 + 4)	(Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	\$		\$	51,297	\$:	51,297	1
	Licensed Speech and Language										
2	Development Therapist		hrs				9,805			9,805	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist		hrs				66,824	504		67,328	4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
			# of								
9	Pharmacy		prescrpts					51,251		51,251	9
	Psychological Services										
	(Evaluation and Diagnosis/										
10	Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program										12
13	Other (specify):						25,982			25,982	13
	<u>-</u>										
					1						
14	TOTAL			\$		\$ 1	153,908	\$ 51,755		\$ 205,663	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

		1	perating	2 After Consolidation*	
	A. Current Assets				
1	Cash on Hand and in Banks	\$	366,067	\$	1
2	Cash-Patient Deposits		5,090		2
	Accounts & Short-Term Notes Receivable-				
3	Patients (less allowance)		333,443		3
4	Supply Inventory (priced at)				4
5	Short-Term Investments				5
6	Prepaid Insurance		61,953		6
7	Other Prepaid Expenses				7
8	Accounts Receivable (owners or related parties)				8
9	Other(specify):				9
	TOTAL Current Assets				
10	(sum of lines 1 thru 9)	\$	766,553	\$	10
	B. Long-Term Assets				
11	Long-Term Notes Receivable				11
12	Long-Term Investments				12
13	Land		83,500		13
14	Buildings, at Historical Cost		3,003,527		14
15	Leasehold Improvements, at Historical Cost				15
16	Equipment, at Historical Cost		495,986		16
17	Accumulated Depreciation (book methods)		(1,493,287)		17
18	Deferred Charges				18
19	Organization & Pre-Operating Costs				19
	Accumulated Amortization -				
20	Organization & Pre-Operating Costs				20
21	Restricted Funds				21
22	Other Long-Term Assets (specify):				22
23	Other(specify):				23
	TOTAL Long-Term Assets				
24	(sum of lines 11 thru 23)	\$	2,089,726	\$	24
	TOTAL ASSETS				
25	(sum of lines 10 and 24)	\$	2,856,279	\$	25

		1	perating	2 After Consolidation*	
	C. Current Liabilities				
26	Accounts Payable	\$	95,199	\$	26
27	Officer's Accounts Payable				27
28	Accounts Payable-Patient Deposits		5,090		28
29	Short-Term Notes Payable				29
30	Accrued Salaries Payable		174,829		30
	Accrued Taxes Payable				
31	(excluding real estate taxes)		483		31
32	Accrued Real Estate Taxes(Sch.IX-B)		2,421		32
33	Accrued Interest Payable		136		33
34	Deferred Compensation				34
35	Federal and State Income Taxes				35
	Other Current Liabilities(specify):				
36	Escrow				36
37					37
	TOTAL Current Liabilities				
38	(sum of lines 26 thru 37)	\$	278,158	\$	38
	D. Long-Term Liabilities				
39	Long-Term Notes Payable				39
40	Mortgage Payable		82,625		40
41	Bonds Payable				41
42	Deferred Compensation				42
	Other Long-Term Liabilities(specify):				
43					43
44					44
	TOTAL Long-Term Liabilities				
45	(sum of lines 39 thru 44)	\$	82,625	\$	45
	TOTAL LIABILITIES				
46	(sum of lines 38 and 45)	\$	360,783	\$	46
		_			
47	TOTAL EQUITY(page 18, line 24)	\$	2,495,496	\$	47
	TOTAL LIABILITIES AND EQUITY				
48	(sum of lines 46 and 47)	\$	2,856,279	\$	48

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12/31/2003

Ending:

^{*(}See instructions.)

Report Period	Beginning:	01/01/2003
---------------	------------	------------

			1		1
1	Dalamas at Daginging of Vasu as Dussianals Dagastal	S	Total	1	
2	Balance at Beginning of Year, as Previously Reported Restatements (describe):	Þ	2,531,032	2	-
3	Restatements (describe).			3	-
4				4	-
5				5	1
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$	2,531,032	6	1
	A. Additions (deductions):				ı
7	NET Income (Loss) (from page 19, line 43)		(35,536)	7	1
8	Aquisitions of Pooled Companies			8	1
9	Proceeds from Sale of Stock			9	1
10	Stock Options Exercised			10	1
11	Contributions and Grants			11	1
12	Expenditures for Specific Purposes			12	1
13	Dividends Paid or Other Distributions to Owners	()	13	1
14	Donated Property, Plant, and Equipment			14	1
15	Other (describe)			15	1
16	Other (describe)			16]
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$	(35,536)	17	
	B. Transfers (Itemize):				
18				18	
19				19	
20				20	
21				21	_
22				22	
23	TOTAL Transfers (sum of lines 18-22)	\$		23	
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$	2,495,496	24	ŀ

^{*} This must agree with page 17, line 47.

0034256 Report Period Beginning: 01

01/01/2003

Ending:

Page 19 12/31/2003

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue All Levels of Care	\$ 2,916,024	1
2	Discounts and Allowances for all Levels	(432,958)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,483,066	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	265,035	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 265,035	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	77	12
13	Barber and Beauty Care	14,128	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	3,080	16
17	Sale of Drugs	112,903	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	1,038	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 131,226	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	3,735	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 3,735	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,883,062	30

		2	
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	597,600	31
32	Health Care	1,390,230	32
33	General Administration	788,727	33
	B. Capital Expense		
34	Ownership	135,588	34
	C. Ancillary Expense		
35	Special Cost Centers	11,645	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37		(5,192)	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,918,598	40
41	Income before Income Taxes (line 30 minus line 40)**	(35,536)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (35,536)	43

*	This must	t agree with	page 4,	line 45,	column 4.
---	-----------	--------------	---------	----------	-----------

*	Does this agree wit	th taxable income (loss) per Federal Income
	Tax Return?	If not, please attach a reconciliation.

^{***} See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

^{****}Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number MASON CITY AREA NURSING HOME

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

11 Social Service Workers 661 960 17,401 18.13 11 12 Dietician 12 13 Food Service Supervisor 13 14 Head Cook 14 15 Cook Helpers/Assistants 21,355 23,031 185,760 8.07 15 16 Dishwashers 16			1	2**	3	4	
Director of Nursing			# of Hrs.	# of Hrs.		Average	
Director of Nursing				Paid and	Total Salaries,	Hourly	
2 Assistant Director of Nursing 8,529 9,558 170,091 17.80 3 4 Licensed Practical Nurses 17,302 18,686 2289,707 15.50 4 4 15.00							
3 Registered Nurses	1	Director of Nursing	1,850	2,085	\$ 50,007	\$ 23.98	1
Licensed Practical Nurses 17,302 18,686 289,707 15.50 4					•		
5 Nurse Aides & Orderlies 43,850 46,884 446,647 9.53 5 6 Nurse Aide Trainees 0 6 7 Licensed Therapist 7 7 8 Rehab/Therapy Aides 5,464 5,972 66,228 11.09 8 9 Activity Director 9 10 Activity Assistants 6,261 6,609 52,728 7.98 10 11 Social Service Workers 661 960 17,401 18.13 11 12 Dietician 12 13 Food Service Supervisor 13 14 Head Cook 14 15 Cook Helpers/Assistants 21,355 23,031 185,760 8.07 15 16 Dishwashers 16 15 Maintenance Workers 5,472 5,872 57,655 9.82 17 18 Housekeepers 6,533 7,302 52,635 7.21 18 19 Laundry 5,360 5,665 41,557 7.34 19 20 Administrator 2,080 2,080 58,234 28.00 <t< td=""><td>3</td><td></td><td></td><td>9,558</td><td></td><td></td><td></td></t<>	3			9,558			
6 Nurse Aide Trainees 0 6 7 Licensed Therapist 7 8 Rehab/Therapy Aides 5,464 5,972 66,228 11.09 8 9 Activity Director 9 10 Activity Assistants 6,261 6,609 52,728 7,98 10 11 Social Service Workers 661 960 17,401 18.13 11 12 Dictician 12 13 Food Service Supervisor 13 14 Head Cook 14 15 Cook Helpers/Assistants 21,355 23,031 185,760 8.07 15 16 Dishwashers 16 16 18 16 18 16 18 16 18 16 18 16 18 16 18 16 18 16 18 16 18 16 16 18 16 18 16 18 18 16 18 18 16 18 18 16 18 1	4		17,302	18,686	289,707	15.50	4
Time	5	Nurse Aides & Orderlies	43,850	46,884	446,647	9.53	5
8 Rehab/Therapy Aides 5,464 5,972 66,228 11.09 8 9 Activity Director 9 9 10 Activity Assistants 6,261 6,609 52,728 7.98 10 11 Social Service Workers 661 960 17,401 18.13 11 12 Dietician 12 13 14 Head Cook 14 15 Cook Helpers/Assistants 21,355 23,031 185,760 8.07 15 16 Dishwashers 16 15 15 15 16 15 16 15 16 15 16 15 16 15 16 15 16 16 16 16 16 16 16 16 18 17 15 16 18 16 18 16 18 17 18 19 18 19 12 16 18 19 12 18 19 12 18 19	6	Nurse Aide Trainees			0		6
9 Activity Director 10 Activity Assistants 6,261 6,609 52,728 7.98 10 11 Social Service Workers 661 960 17,401 18.13 11 12 Dictician 12 Dictician 13 Food Service Supervisor 14 Head Cook 15 Cook Helpers/Assistants 16 Dishwashers 16 Dishwashers 17 Maintenance Workers 18 Housekeepers 19 Laundry 19 Laundry 19 Laundry 19 Laundry 19 Laundry 10 Administrator 20 Administrator 21 Assistant Administrator 21 Assistant Administrator 22 Other Administrative 23 Office Manager 24 Clerical 25 Vocational Instruction 26 Academic Instruction 27 Medical Director 28 Qualified MR Prof. (QMRP) 29 Resident Services Coordinator 30 Habilitation Aides (DD Homes) 31 Medical Records 31 Other (specify) 32 Other (specify) 33 Other(specify)	7	Licensed Therapist					7
10 Activity Assistants 6,261 6,609 52,728 7.98 10 11 Social Service Workers 661 960 17,401 18.13 11 12 Dictician	8	Rehab/Therapy Aides	5,464	5,972	66,228	11.09	8
11 Social Service Workers 661 960 17,401 18.13 11 12 Dietician 12 13 Food Service Supervisor 13 14 Head Cook 14 15 Cook Helpers/Assistants 21,355 23,031 185,760 8.07 15 16 Dishwashers 16	9	Activity Director					9
12 Dietician 12 13 Food Service Supervisor 13 14 Head Cook 14 15 Cook Helpers/Assistants 21,355 23,031 185,760 8.07 15 16 Dishwashers 16 17 Maintenance Workers 5,472 5,872 57,655 9.82 17 18 Housekeepers 6,533 7,302 52,635 7.21 18 19 Laundry 5,360 5,665 41,557 7.34 19 20 Administrator 2,080 2,080 58,234 28.00 20 21 Assistant Administrator 21 22 Other Administrative 22 23 Office Manager 23 24 Clerical 9,210 9,917 146,542 14.78 24 25 Vocational Instruction 26 Academic Instruction 26 Academic Instruction 26 Academic Instruction 27 28 Qualified MR Prof. (QMRP) 28 Qualified MR Prof. (QMRP) 28 29 Resident Services Coordinator 30 Habilitation Aides (DD Homes) 31 Medical Records 31 32 Other Health Care(specify) 33 30 Other(specify) 33 30 Other(specify) 33 30 Other(specify) 33 30 Other(specify) 33 30 30 30 30 Other(specify) 33 30 30 30 Other(specify) 30 30 30 30 30 30 30 3	10	Activity Assistants	6,261	6,609	52,728	7.98	10
13 Food Service Supervisor 13 14 Head Cook 14 15 Cook Helpers/Assistants 21,355 23,031 185,760 8.07 15 16 Dishwashers 16 17 Maintenance Workers 5,472 5,872 57,655 9.82 17 18 Housekeepers 6,533 7,302 52,635 7,21 18 19 Laundry 5,360 5,665 41,557 7.34 19 20 Administrator 2,080 2,080 58,234 28.00 20 21 Assistant Administrator 21 22 Other Administrative 22 23 Office Manager 23 24 Clerical 9,210 9,917 146,542 14.78 24 25 Vocational Instruction 25 Academic Instruction 26 Academic Instruction 27 Medical Director 27 Medical Director 27 28 Qualified MR Prof. (QMRP) 28 29 Resident Services Coordinator 30 Habilitation Aides (DD Homes) 31 Medical Records 31 32 Other Health Care(specify) 33 33 Other(specify) 33 33 Other(specify) 33 33 Other(specify) 33 33 30 Other(specify) 33 33 30 Other(specify) 33 34 35 34 34 34 34 34	11	Social Service Workers	661	960	17,401	18.13	11
14 Head Cook							12
14 Head Cook	13	Food Service Supervisor					13
16 Dishwashers 16 17 Maintenance Workers 5,472 5,872 57,655 9.82 17 18 Housekeepers 6,533 7,302 52,635 7.21 18 19 Laundry 5,360 5,665 41,557 7.34 19 20 Administrator 2,080 2,080 58,234 28.00 20 21 Assistant Administrator 21 22 Other Administrative 22 23 Office Manager 23 24 Clerical 9,210 9,917 146,542 14.78 24 25 Vocational Instruction 25 26 Academic Instruction 26 Academic Instruction 27 Medical Director 27 28 Qualified MR Prof. (QMRP) 28 29 Resident Services Coordinator 30 Habilitation Aides (DD Homes) 31 Medical Records 31 32 Other Health Care(specify) 33 33 Other(specify) 33 33 Other(specify) 33 33 30 Other(specify) 33 33 30 Other(specify) 33 33 30 34 Medical Records 33 33 34 34 34 34 34 3	14	Head Cook					14
17 Maintenance Workers 5,472 5,872 57,655 9.82 17 18 Housekeepers 6,533 7,302 52,635 7.21 18 19 Laundry 5,360 5,665 41,557 7.34 19 20 Administrator 2,080 2,080 58,234 28.00 20 21 Assistant Administrator 21 22 Other Administrative 22 23 Office Manager 23 24 Clerical 9,210 9,917 146,542 14.78 24 25 Vocational Instruction 26 Academic Instruction 26 Academic Instruction 26 Academic Instruction 27 Medical Director 27 28 Qualified MR Prof. (QMRP) 28 29 Resident Services Coordinator 30 Habilitation Aides (DD Homes) 31 Medical Records 31 32 Other Health Care(specify) 33 33 Other(specify) 33 33 Other(specify) 33 33 30 Other(specify) 33 33 30 Other(specify) 33 33 30 34 Medical Records 35 35 35 36 36 36 36 36	15	Cook Helpers/Assistants	21,355	23,031	185,760	8.07	15
18 Housekeepers	16	Dishwashers					16
19 Laundry	17	Maintenance Workers	5,472	5,872	57,655	9.82	17
19 Laundry	18	Housekeepers	6,533	7,302	52,635	7.21	18
21 Assistant Administrator 21 22 Other Administrative 22 23 Office Manager 23 24 Clerical 9,210 9,917 146,542 14.78 24 25 Vocational Instruction 25 26 Academic Instruction 26 27 Medical Director 27 28 Qualified MR Prof. (QMRP) 28 29 Resident Services Coordinator 29 30 Habilitation Aides (DD Homes) 30 31 Medical Records 31 32 Other Health Care(specify) 32 33 Other(specify) 33	19	Laundry	5,360	5,665		7.34	19
22 Other Administrative 22 23 Office Manager 23 24 Clerical 9,210 9,917 146,542 14.78 24 25 Vocational Instruction 25 26 Academic Instruction 26 27 Medical Director 27 28 Qualified MR Prof. (QMRP) 28 29 Resident Services Coordinator 29 30 Habilitation Aides (DD Homes) 30 31 Medical Records 31 32 Other Health Care(specify) 32 33 Other(specify) 33	20	Administrator	2,080	2,080	58,234	28.00	20
23 Office Manager 23 24 Clerical 9,210 9,917 146,542 14.78 24 25 Vocational Instruction 25 26 Academic Instruction 26 27 Medical Director 27 28 Qualified MR Prof. (QMRP) 28 29 Resident Services Coordinator 29 30 Habilitation Aides (DD Homes) 30 31 Medical Records 31 32 Other Health Care(specify) 32 33 Other(specify) 33	21	Assistant Administrator					21
24 Clerical 9,210 9,917 146,542 14.78 24 25 Vocational Instruction 25 26 Academic Instruction 26 27 Medical Director 27 28 Qualified MR Prof. (QMRP) 28 29 Resident Services Coordinator 29 30 Habilitation Aides (DD Homes) 30 31 Medical Records 31 32 Other Health Care(specify) 32 33 Other(specify) 33	22	Other Administrative					22
25 Vocational Instruction 25 26 Academic Instruction 26 27 Medical Director 27 28 Qualified MR Prof. (QMRP) 28 29 Resident Services Coordinator 29 30 Habilitation Aides (DD Homes) 30 31 Medical Records 31 32 Other Health Care(specify) 32 33 Other(specify) 33	23	Office Manager					23
26 Academic Instruction 26 27 Medical Director 27 28 Qualified MR Prof. (QMRP) 28 29 Resident Services Coordinator 29 30 Habilitation Aides (DD Homes) 30 31 Medical Records 31 32 Other Health Care(specify) 32 33 Other(specify) 33	24	Clerical	9,210	9,917	146,542	14.78	24
27 Medical Director 27 28 Qualified MR Prof. (QMRP) 28 29 Resident Services Coordinator 29 30 Habilitation Aides (DD Homes) 30 31 Medical Records 31 32 Other Health Care(specify) 32 33 Other(specify) 33	25	Vocational Instruction		ĺ	,		25
28 Qualified MR Prof. (QMRP) 28 29 Resident Services Coordinator 29 30 Habilitation Aides (DD Homes) 30 31 Medical Records 31 32 Other Health Care(specify) 32 33 Other(specify) 33	26	Academic Instruction					26
29 Resident Services Coordinator 29 30 Habilitation Aides (DD Homes) 30 31 Medical Records 31 32 Other Health Care(specify) 32 33 Other(specify) 33	27	Medical Director					27
30 Habilitation Aides (DD Homes) 30 31 Medical Records 31 32 Other Health Care(specify) 32 33 Other(specify) 33	28	Qualified MR Prof. (QMRP)					28
31 Medical Records 31 32 Other Health Care(specify) 32 33 Other(specify) 33	29	Resident Services Coordinator					29
32 Other Health Care(specify)3233 Other(specify)33	30	Habilitation Aides (DD Homes)					30
32 Other Health Care(specify)3233 Other(specify)33	31	Medical Records					31
33 Other(specify) 33							32
							33
34 10 1 AL (IIIC) 1 - 33 133,727 144,021 3 1,033,172 3 11.31 34		TOTAL (lines 1 - 33)	133,927	144,621	s 1,635,192 *	\$ 11.31	34

^{*} This total must agree with page 4, column 1, line 45.

B. CONSULTANT SERVICES

		1	2	3	
		Number	Total Consultant	Schedule V	
		of Hrs.	Cost for	Line &	
		Paid &	Reporting	Column	
		Accrued	Period	Reference	
35	Dietary Consultant		\$ 0		35
36	Medical Director		9,000		36
37	Medical Records Consultant		0		37
38	Nurse Consultant				38
39	Pharmacist Consultant		0		39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant		925		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		s 9,925		49

C. CONTRACT NURSES

		1	2	3	
		Number		Schedule V	
		of Hrs.	Total	Line &	
		Paid &	Contract	Column	
		Accrued	Wages	Reference	
50	Registered Nurses	0	s 0		50
51	Licensed Practical Nurses	0	0		51
52	Nurse Aides	0	0		52
53	TOTAL (lines 50 - 52)		\$		53
		·= '		·=·	

^{**} See instructions.

STATE ()F ILL	INOIS
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Line#

Amount

0034256

MASON CITY AREA NURSING HOME Ending: 12/31/2003 Facility Name & ID Number **Report Period Beginning:** XIX. SUPPORT SCHEDULES A. Administrative Salaries Ownership D. Employee Benefits and Payroll Taxes F. Dues, Fees, Subscriptions and Promotions Description Description Name Function % Amount Amount Amount IDPH License Fee Joyce Conrady 58,234 Workers' Compensation Insurance 37,736 0 Admin **Unemployment Compensation Insurance** 3,246 Advertising: Employee Recruitment 1,161 Health Care Worker Background Check FICA Taxes 125,092 **Employee Health Insurance** 121,132 (Indicate # of checks performed 259 Employee Meals Central Office Allocation Illinois Municipal Retirement Fund (IMRF)* Promotional Advertising 2,305 Public Relations **Employee Hepatitis Vaccine** 4,028 TOTAL (agree to Schedule V, line 17, col. 1) Employee Benefits -28,244 Dues and Subscriptions 5,911 (List each licensed administrator separately.) 58,234 **Employee Benefits - central office** License and Fees (6,860)B. Administrative - Other Less: Public Relations Expense (4,028)Description Non-allowable advertising **(40)** Amount Yellow page advertising (2,305)TOTAL (agree to Schedule V, TOTAL (agree to Sch. V, 431 315,450 line 22, col.8) line 20, col. 8) TOTAL (agree to Schedule V, line 17, col. 3) E. Schedule of Non-Cash Compensation Paid G. Schedule of Travel and Seminar** (Attach a copy of any management service agreement) to Owners or Employees C. Professional Services Description Amount

* Attach copy of IMRF notifications

Description

TOTAL

Amount

96,001

516

0

8,574 0

110,041

4,950 0

Vendor/Pavee

Carmin Little

Abbott & Co

Heritage Enterprises

Legal Fees (Adjusted to zero)

TOTAL (agree to Schedule V, line 19, column 3)

(If total legal fees exceed \$2500 attach copy of invoices.)

Type

Consultant

Audit

Management Fees

TOTAL

Out-of-State Travel

In-State Travel

Seminar Expense Non Allowable

Central Office Allocation

Entertainment Expense

(agree to Sch. V,

line 24, col. 8)

Page 21

3,016 135 2,293

(3,445)

1,999

01/01/2003

^{**}See instructions.

Report Period Beginning: 01/01/2003

Ending:

Page 22 12/31/2003

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).

	(See instructions.)							-,,-					
	1	2	3	4	5	6	7	8	9	10	11	12	13
		Month & Year					,	Amount of	Expense Amor	tized Per Year	,		
	Improvement Type	Improvement Was Made	Total Cost	Useful Life	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		ls		S	s	s	s	s	s	\$	s	s

Facility	y Name & ID Number MASON CITY AREA NURSING HOME	STATE (OF ILLINOIS 0034256	Report Period Beginning:	01/01/2003	Ending:	Page 23 12/31/200
XX. G	ENERAL INFORMATION:						
(1)	Are nursing employees (RN,LPN,NA) represented by a union?	(13)		applies and services which are of the Public Aid, in addition to the daily			
(2)	Are there any dues to nursing home associations included on the cost report? If YES, give association name and amount. Illinois Healthcare Association		Ž	etion of Schedule V? Yes			
(3)	Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? Yes	(14)	the patient census lis a portion of the b	uilding used for any function other isted on page 2, Section B? No uilding used for rental, a pharmacy eplains how all related costs were a	, day care, etc.)	For example If YES, attac	e,
(4)	Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity?	(15)	Indicate the cost of on Schedule V. related costs?		assified to emplo y meal income be e the amount. \$	een offset ag	ainst
(5)	Have you properly capitalized all major repairs and equipment purchases? What was the average life used for new equipment added during this period? Yes 7 Years	(16)	Travel and Transpo	rtation acluded for out-of-state travel?	No		
(6)	Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 5,000 Line 10		If YES, attach a	complete explanation. parate contract with the Department	nt to provide med		
(7)	Have all costs reported on this form been determined using accounting procedures consistent with prior reports? If NO, attach a complete explanation.		c. What percent of d. Have vehicle usa	his reporting period. \$ all travel expense relates to transpoge logs been maintained? Yes	rtation of nurses	and patients	
(8)	Are you presently operating under a sale and leaseback arrangement? If YES, give effective date of lease.		times when not i	tored at the nursing home during the use? Yes ommuting or other personal use of			
(9)	Are you presently operating under a sublease agreement? YES xx NO	O	out of the cost re		-		
(10)	Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO No If YES, please indicate name of the facility IDPH license number of this related party and the date the present owners took over.	y,	Indicate the ar	nount of income earned from during this reporting period.	providing such		_
		(17)	Firm Name: Ab	erformed by an independent certification bott & Co	•	The instruct	tions for the
(11)	Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\		been attached?	hat a copy of this audit be included If no, please explain.	Not Complet		
(12)	Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.		out of Schedule V?	h do not relate to the provision of l	-		
		(19)	performed been atta	e in excess of \$2500, have legal in ached to this cost report? I a summary of services for all arch		-	ices

43,000 ant/mic just/271 1,001,021 -1,002,022 -0,000 -40,000 -40,000 -40,000 -40,000 -40,000 .36 .3,61 .4,66 .43,63 an harmon M.(M. 1400